The Anxious Patient

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■ *Anxiety appears in many disguises and mimics most other afflictions. Once the anxious patient has been recognized as such and a proper diagnosis is made, management of him is easily carried out within the framework of the medical transaction. Lack of awareness of underlying anxiety in a patient who presents with somatic complaints can lead to poor results for the patient and frustration for the physician. It is not the physician's role to remove all anxiety. Rather, it is his mission to manage the anxious patient so as to mediate the anxiety allowing for integrated adaptive function.*

ANXIETY is the most frequent cause for a patient's seeking the help of a physician. Since it can mimic most other afflictions, it is presented to the physician in many disguises. Anxiety is a danger signal, heralding a threat to the core of human existence. As such it is necessary for preserving physical health and maintaining psychological balance.[6] Many papers have appeared in the medical literature speculating upon the meaning and the philosophy of anxiety. In the psychiatric literature, there are attempts to classify anxiety and to differentiate various types of adaptive and mal-adaptive forms, but the present discussion is focused on the recognition and management of the anxious patient who seeks help within the framework of the medical transaction.

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Recognizing the Anxious Patient

Not very many anxious patients present themselves to the nonpsychiatrist physician with an initial complaint of anxiety. Usually the patient's complaint is one of a wide spectrum of vague or specific somatic symptoms. The particular complaint he chooses as his "entrance ticket" into the medical transaction is determined not only by the particular physiological manifestation of his anxiety but also by the specialty and the interest of the physician from whom the patient is seeking help.

To what extent the "entrance ticket" is determined by the interest of the physician is very clearly demonstrated in a setting such as a county hospital, where one patient may visit many specialty clinics concurrently. In a review of the charts of patients who attended more than five clinics at the same time, it became clear that in each clinic a different aspect of the patient's anxiety was presented and treated. The same patient during the same week

would discuss his fears and worries in the psychiatric clinic, his gas pains and diarrhea in the gastrointestinal clinic, his headaches and dizziness in the neurology clinic and his incapacitating back pain in the orthopedic clinic. All of these complaints were real and all of these symptoms were manifestations of the same anxiety in the same patient during a specific week.[4]

How is it, then, that the content of the transaction in each of these clinics was so different? This question can best be answered by observing initial interviews. Such observations demonstrate that much of what we hear from the patient is dictated by the clues to our interest which we give the patient. Many times these clues are more important in determining the patient's chief complaint than is his own concern. Contact with the physician as a representative of a helping situation is highly valued by most patients and endowed with much magic.

Within the framework of the medical transaction most patients, particularly the chronically ill who are very much in need of the physician's interest and concern, will do almost anything to please him.[2] When the physician begins the encounter with, "What brings you here?", the patient might well reply with: "I haven't been feeling well, Doc. For the last few weeks I have been worried, my back hurts all the time and I have lots of trouble with my gut. Besides that, I have lots of headaches and I feel dizzy. I wonder whether I am getting old."

The physician then might reply, depending on his interest, with, "What are these headaches like?" Or, he might say, "How often do you have a stool each day?"

After the physician has presented his interest to the patient by this type of questioning, very frequently the content of the entire transaction between the patient and the physician is determined. The patient discusses his anxiety in terms of that symptom in which the physician has expressed an interest. The physician treats that symptom of anxiety which is consistent with his specialty. Indeed, the entire management of the anxiety may be carried out by the physician within the metaphor of a particular organ system determined by the specialty of the physician. At times in the hands of the inexperienced physician this may lead to much unnecessary medical and surgical intervention which is of limited help to the patient. Thus, the initial complaint, the entrance ticket of the patient into the helping situation, may indeed only be a peripheral manifestation of the problem of anxiety. If the physician does not recognize the chief complaint as a mere entrance ticket, he may easily be led astray and subsequently find himself frustrated in the recognition that his intervention proved ineffective. The presenting complaint thus is seen by the experienced physician as a token in order to obtain listening, understanding and concern. The experienced physician who accepts the patient's admission ticket in these terms then gives him the opportunity to pursue his real concern. Frequently he will hear no further mention of the symptoms which serve to bring the patient to the physician.

The somatic symptoms presented to the physician by the anxious patient are not only determined by the interpersonal transaction but also by the specific processes within the patient. Patients develop a target area or an organ system which is most readily available as a focus for anxiety. This "locus resistentia minoris" is determined not only by the genetics and previous medical history, but also by many other factors of internal and external environment. In terms of such a view, the concept of a physiological personality emerges.[5] Most usually, personality refers to a psychological abstraction which describes a particular pattern of adaptive mechanisms with which the individual copes with internal and external stresses. Personality is that coping behavior which is characteristic for a particular individual. Similarly, we could say that an individual has a pattern of physiological responses to both emotional and physical stress which is characteristic for him and which is determined by a multitude of factors. One might well think of this in terms of a physiological personality. Once we recognize that psychological and physiological coping behavior is determined by the total history of the individual, the multiplicity of presenting complaints of the anxious patient becomes much more understandable.

The theoretical approach to the understanding of the physiological manifestations of anxiety has undergone major changes during the past 60 years. In the early times of modern psychological medicine, interest was focused on the somatic manifestations as symbolic representations of the content of conflicts leading to anxiety. Psychophysiological reactions were viewed as synonymous to conversion reactions in which the particular symptom choice was a symbolic representation of the conflict. This view could not be supported either by research or by logic. This earliest conceptualization was replaced by the idea that each patient had a personality type which was consistent with only one kind of physiological manifestation of anxiety. Although somewhat similar to the "locus resistentia minoris" concept previously mentioned, this approach did imply that certain kinds of physiological manifestations were mutually exclusive. For example, in this system it was impossible for a person with an "ulcer personality" to develop asthma because the "asthma personality" was postulated to be quite different. These theoretical formulations had to be

discarded because they were not borne out by fact.

During the past 25 years Dr. Franz Alexander, the father of contemporary psychosomatic medicine,[1] developed a conceptual framework in which the somatic manifestation of anxiety is related to the specific conflict in the patient. For example, if the conflict related to the problem of dependency-independency, then the somatic manifestation might well involve that organ system in which the issue of dependency was first encountered, namely, the upper gastrointestinal tract. This conceptual model was most useful in psychodynamic research of specific psychosomatic disorders. However, even this theory required the presence of a postulated x factor in the chain of causality.

In recent years under the influence of Stewart Wolf's theory of causality of the "relevant etiological factor" and Maxwell Gitelson's critique of current concept of psychosomatic medicine, we have begun to ask a new kind of question. While formerly the physician had asked, "What causes this illness or symptom?" and had expected a simple, clear answer in accordance with Koch's postulates, now the complexities of the causal chain became ever more apparent and could not be conceived in such a simple, theoretical framework.

The contemporary physician must seek that peculiar combination of biological, psychological, social and cultural forces which impinge upon the patient to produce a symptom or an illness. The new question is, "What conditions taken together make it possible for this symptom to emerge in this patient at this time?" Such a multi-dimensional approach to the understanding of the meaning of symptoms takes full recognition of the fact that no two individuals are the same. Thus, the same symptom in two different individuals may have entirely different meaning. Furthermore, a similar symptom in the same individual at different times may require a different kind of understanding. This multi-dimensional view of illness allows the physician to see the symptom as the final common path of a multitude of dynamic interacting forces which impinge upon the anxious patient as he presents himself for help.

Management of the Anxious Patient

The most potent agent in the management of the anxious patient is the therapeutic exploitation of the physician-patient relationship.[3] By the very nature of the traditional medical contract, the role of the physician and the role of the patient is defined. The patient expects help, comfort, advice, healing and even magic. The physician attempts to meet these expectations. These expectations, if consciously and properly managed by the physician, can become potent therapeutic agents. The physician who is seen as the representative of the helping situation and who is endowed with all the wisdom and all the magical powers previously bestowed upon the high priests and the parents, is a powerful authority figure. This power of the physician to relieve anxiety is demonstrated in the instant relief frequently seen when a patient merely has an appointment to see the helper. At the moment in which the patient contracts with the physician for care, treatment of anxiety has begun.

There are many techniques for reinforcing this built-in, therapeutic intent of the medical transaction. These techniques include the physician's interest, concern, hope and reassurance. From the outset, the medical transaction implies therapeutic intent. The very fact that a physician and a patient get together for a medical transaction demonstrates interest, that change and help is possible, that this is the beginning of a helping relationship—the possible beginning of health and an open future. The transaction must emphasize hope;[8] it must demonstrate the therapeutic attitude of the physician.

Perhaps the simplest maneuver by which this can be accomplished is to let the patient know that the physician will offer future appointments. Even in a hopeless medical situation we ought not close the door. We do not say to the patient, "There is nothing I can do for you medically; don't bother coming back to waste your money and my time." Of course none of us would say this to a patient with terminal cancer. But how many of us might say something of the kind to the suffering, anxious patient who is not responding to treatment. Since physicians have recognized that giving hope is an important aspect of treatment and that helping and comforting a patient we cannot cure is one of the important functions of medicine, we can readily see that many chronically anxious patients are deprived of adequate and proper medical care. This in no way implies that the physician should ever make promises or should ever be unrealistically optimistic or misleading.[10] It does imply that in the medical transaction in which a physician and a patient get together, hope and help are built into the structure and should be allowed to remain there. The patient has the right to expect this from the helping situation. Furthermore, he has the right to take something home from each contact in the medical transaction. At times, this is advice or a diagnosis or a prescription; at other times, it is the feeling that it is possible to be understood.

The anxious patient responds well to reassurance. We have already indicated that much reassurance is built into the physician-patient transaction. However, there are some specific techniques of reassurance which can be learned and which, if carried out, prove most effective. The reassuring activity

by the physician consists of (1) letting the patient know that his feelings of anxiety are recognized, (2) that he is allowed to talk about these feelings if he wishes, and (3) that his anxiety can be accepted by the physician with a non-judgmental attitude. For example, when a physician carries out a medical procedure of which the patient is frightened, the most reassuring statement he can make is to say to the patient, "I guess you are frightened." This simple statement communicates the three attitudes previously enumerated. It lets the patient know that his feelings are recognized, that he may talk about these feelings if he wishes, and that the physician is willing to listen without judging the patient to be a coward or a fool. Many times such a simple, gentle confrontation provides prompt and effective reassurance. If the physician had said, "Now, don't be afraid"—which on the surface might appear to be reassuring—he might discover in fact that the patient's anxiety increased. Such a statement might imply to the patient that he should not be afraid, that the physician cannot understand such fears and will not tolerate or accept such an attitude.

From the foregoing discussion, it becomes clear that "doing what comes naturally" can lead to error in the treatment of patients. Many physicians, meaning to reassure the patient who is about to cry, will be tempted to say, "Now, don't you cry." Or they may say, "Don't worry," to the patient who, if he could respond to such a simple command, would never have come to the physician for help.

Use of Drugs

In recent years drugs have become a useful adjunct in the treatment of anxious patients. Since it is difficult to separate the pharmacological from the psychological effect of tranquilizers, very little accurate information on the specific pharmacological effectiveness is available. Unfortunately, the importance of these drugs has been somewhat overrated and over-valued. Many of the drugs indeed do not produce "tranquillity," but rather relieve some of the tension and provide sedation. If we view the modern tranquilizers as slight improvements over the barbiturates and if we see them as useful adjuncts in the management of the anxiety-ridden patient rather than as specific drugs, then we can make much more realistic use of them. Most anxious patients, when they are offered a helping relationship, do not require tranquilizers. Some patients take the tranquilizers in lieu of or as a symbol for the helping situation. A few patients require some chemical help in dealing with their anxiety, and for this small group tranquilizers are of considerable value. In general, the best drugs are those which have been used the most and thus with which we have the most experience; these are phenothiazines such as chlorpromazine (Thorazine®), and minor tranquilizers such as meprobamate and chlordiazepoxide (Librium®). Experience shows very little predictable difference between the various tranquilizers, although specific patients may respond better to one or the other. The least amount of the drug for the shortest period of time possible should be used in the management of the anxious patient. Since the tranquilizers decrease not only the awareness of internal tension but also of the outside world, they may indeed interfere with the value of the therapeutic relationship.

Vigorous attack upon specific symptoms of anxiety with drugs, with surgical operation or with hypnosis has, at times, proven ineffective and even detrimental. The patient's response to the medical intervention can be predicted to a large extent from a knowledge of his particular life-situation and life-style. How important particular symptoms have become in the life of the patient will determine how readily the patient can give these up. If a symptom or disability has persisted for some time and has been incorporated into the life-style, then medical and surgical intervention may not result in relief of incapacity even though the specific symptom be removed. At times, removal of a specific symptom may indeed cause the appearance of a more malignant group of symptoms, including major personality disorganization.[9] It is for this reason that hypnosis should not be used for removal of functional symptoms without a careful and skilled psychiatric evaluation. Only when a patient is psychologically ready to give up a specific symptom of anxiety will he respond satisfactorily to the treatment intervention for specific symptoms.

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